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BULLETIN NASTAD HIV PREVENTION

May 2006

National Alliance of State and Territorial AIDS Directors

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Focus on Viral Hepatitis

In observance of Viral Hepatitis Awareness Month, NASTAD's May 2006 *HIV Prevention Bulletin* focuses on viral hepatitis. Several activities are planned around the country related to National Viral Hepatitis Awareness month. For example, on Tuesday, May 9, in Sacramento, California, the O.A.S.I.S. Clinic, Hepatitis C Support Project, Education for Healthy Choices, and Center for Health Improvement are sponsoring the first ever statewide conference on disparities in hepatitis C infection, the HCV Disparities Conference. The agenda includes a panel on HCV in California, along with sessions focused on advocacy, criminal justice issues, successful national approaches, education and prevention, testing and treatment, and ethnic, cultural and language disparities. *For more information, contact Leslie Benson or call (916) 454-5431.*

The following stories profile research and recent action to generate support for addressing viral hepatitis. Many stories touch on the fact that viral hepatitis stakeholders are seeking leadership from the Department of Health and Human Services (HHS) on viral hepatitis and share the concerns facing programs including the challenge of developing viral hepatitis prevention and surveillance programs in the absence of adequate federal funding. *For more information, visit the U.S. Centers for Disease Control and Prevention's Division of Viral Hepatitis (DVH) website.*

Hepatitis Update

In 2003, there were an estimated 164,000 new hepatitis A, B and C (viral hepatitis) virus infections in the U.S. and approximately 15,000 viral hepatitis-related deaths[1], despite the existence of effective disease prevention measures. Vaccines to prevent hepatitis A (HAV) and hepatitis B (HBV) have been available for over 10 years[2,3] and guidelines to screen, counsel and test populations at risk of hepatitis C virus (HCV) infection were developed and recommended by the U.S. Centers for Disease Control and Prevention (CDC) in 1998.[4] Unfortunately, implementation of these life-saving prevention measures has been limited due to lack of funding, and thousands of preventable infections and deaths continue to occur, at a cost of billions of dollars to our nation each year.[5,6,7,8,9]

The Division of Viral Hepatitis (DVH) at CDC provides the scientific and programmatic foundation for the prevention, control, and elimination of hepatitis virus infections in the U.S., and assists the international public health community in these activities. In FY2006 DVH received $21.5 million to address viral hepatitis, of which nearly $17 million was provided to address hepatitis C. Approximately $4 million of this is used to fund the hepatitis C coordinator program. This program provides funding to states to support a hepatitis C coordinator, who is responsible for increasing hepatitis C awareness and education and working with other public health programs to integrate hepatitis services into existing public health settings. The average funding award for the coordinator position is $80,000, which doesn't even cover personnel costs adequately and leaves no funding for the provision of services. Unfortunately, due to the funding rescissions by Congress, DVH has lost funding for the third year in a row and is unable to provide any increases to the coordinator program in FY2006. The continued cuts impede public health prevention and control efforts in states and localities across the U.S.

DVH is currently located in CDC's National Center for Infectious Diseases (NCID); however, DVH will be moved to CDC's National Center for HIV, STD and TB Prevention (NCHSTP) in October, 2006. This change will increase coordination across HIV, STD, TB and viral hepatitis programs, which provide prevention services to similar populations. Transmitted in many of the same ways, viral hepatitis and HIV/AIDS are infectious diseases that have drastic, long-term medical, economic, and social consequences for those infected with either or both viruses. Meeting the challenges posed by viral hepatitis requires close coordination with existing state and territorial

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HIV/AIDS programs.

The NASTAD Viral Hepatitis Program has been funded by CDC to develop a comprehensive model for coordination between HIV/AIDS and viral hepatitis programs. NASTAD works in partnership with CDC and other agencies to address viral hepatitis needs and resources, and integrates attention to viral hepatitis across its programs. NASTAD provides significant technical assistance to state and local hepatitis C coordinators through a Viral Hepatitis Work Group, facilitating networking and sharing of peer-based materials. NASTAD has published numerous documents focused on co-infection and integration of viral hepatitis with HIV/AIDS care and prevention programs. In 2004, NASTAD compiled all of its viral hepatitis resources to date electronically into one guide, *Viral Hepatitis and HIV: A Resource Guide for HIV/AIDS Programs*.

NASTAD also convenes the Hepatitis C Appropriations Partnership (HCAP), a coalition of hepatitis C community based organizations, public health and provider associations, national HIV and HCV organizations, and members of the diagnostics and pharmaceutical industry who are working together with policy makers and public health officials to increase federal support for hepatitis C prevention, testing, education, and treatment. In addition, NASTAD's ADAP Crisis Task Force has worked to increase access to hepatitis C treatments for HIV/HCV co-infected individuals by negotiating supplemental rebates, discounts and a free treatment program for AIDS Drug Assistance Program (ADAP) clients. NASTAD has also worked to increase access to hepatitis A and B vaccines for ADAP through negotiated discounts/rebates with manufacturers of these vaccines.

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The National Viral Hepatitis Roundtable Call to Action

The National Viral Hepatitis Roundtable (NVHR) will soon unveil its national plan entitled, "Eliminating Hepatitis: A Call to Action." This strategy, collaboratively developed by a coalition of more than 100 organizations over a period of two years, is calling upon those committed to the cause to work together to bring an end to the suffering caused by viral hepatitis in the U.S. NVHR includes hepatitis advocacy groups, medical and nursing associations, public health agencies, drug treatment programs, HIV/AIDS and STD networks, correctional organizations, insurers, and biopharmaceutical companies and is the only national coalition focused on all aspects of viral hepatitis. Members of NVHR pursue legislation, research, prevention strategies, and clinical care to address the myriad of challenges viral hepatitis presents. It works together in partnership to enhance progress on individual activities.

NVHR's national plan includes four primary recommendations:

Goal 1: Build the capacity to eradicate viral hepatitis
This goal centers on the need to develop the capacity in states and territories to improve laboratory tests, develop new treatments, and support health systems research. NVHR calls for the creation of a national surveillance network and funding for patient outreach and education, vaccination, counseling, screening and testing programs. It also calls for comprehensive care for the uninsured, including programs available through community health centers that care for incarcerated persons, drug users and those who have suffered health disparities.

Goal 2: Vaccinate America
NVHR strives to achieve universal hepatitis A and hepatitis B immunization, protecting newborns immediately with hepatitis B vaccine, 1-year olds with hepatitis A vaccine, and requiring vaccination against both diseases for school entry. Special efforts are needed to vaccinate everyone at risk, accelerate development of a hepatitis C vaccine, and protect Americans by reaching out to the world to vaccinate all people.

Goal 3: Counsel, test, and refer persons at risk for viral hepatitis
This goal stresses making all Americans aware of viral hepatitis, creating counseling, testing and referral (CTR) programs to reach those who are infected, and giving them information and appropriate tests, as well as improving the quality of the tests and the laboratories that make diagnoses.

Goal 4: Care for persons with chronic hepatitis
NVHR calls for expanded access to care and the promotion of care based on the best guidelines. It seeks revision in the criteria that determine when an individual, already devastated by disease, is disabled for the purpose of receiving disability benefits.

Defeating viral hepatitis requires strong partnerships such as those forged by the NVHR that can collectively develop the best policies, encourage the best healthcare practices, and secure the funding needed to accomplish this mission. While NVHR's coalition began in the U.S., it will ultimately extend beyond the border. NVHR invites others to join in this effort and support their plan.

For more information, visit the NVHR website.

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CDC Recommends Hepatitis a Vaccine for MSM

Hepatitis A virus infection (HAV) can produce either asymptomatic or symptomatic infection. The average incubation period is 28 days (range: 15–50 days). Illness caused by HAV infection typically has an abrupt onset that can include fever, malaise, anorexia, nausea, abdominal discomfort, dark urine, and jaundice. Among adults, infection typically is symptomatic, with jaundice occurring in more than 70 percent of patients. Symptoms typically last less than two months, although 10–15 percent of symptomatic persons have prolonged or relapsing disease lasting up to six months.

Person-to-person transmission by the fecal-oral route is the primary means of HAV transmission in the U.S. Transmission occurs most frequently among close contacts, especially in households and extended family settings.

The costs associated with hepatitis A are substantial. Surveillance data indicate that 15–22 percent of persons with hepatitis A are hospitalized. The average duration of work loss for adults who become ill has been estimated at 15.5 days for non-hospitalized patients and 33.2 days for hospitalized patients. Estimates of the annual direct and indirect costs of hepatitis A in the U.S. have ranged from $300 million to nearly $5 million in 1997 dollars.

Prior to 1995, before a safe and effective vaccine was available, the majority of U.S. cases of hepatitis A resulted from person-to-person transmission during community-wide outbreaks. The most frequently reported source of infection (12–26 percent) among reported cases was household or sexual contact with a person with hepatitis A. Occasional outbreaks occurred among drug users (both injectors and non-injectors) and among men who have sex with men (MSM).

In 1996, a vaccine to prevent HAV became widely available and CDC subsequently implemented a childhood hepatitis A vaccination program which has dramatically reduced HAV in the U.S. As a result, HAV is increasingly a disease of at-risk adults (e.g., drug users, MSM, foreign travelers, and household contacts of infected individuals).

In 2004, a total of 5,683 cases (rate: 1.9 cases per 100,000 population) were reported, representing an estimated 24,000 acute clinical cases when underreporting is taken into account. This rate was the lowest ever recorded and was 79 percent lower than the previous historic low in 1992. However, outbreaks among MSM and users of illicit drugs continue to occur.

CDC recommends vaccination for:

- Persons who travel or work anywhere except the U.S., Western Europe, New Zealand, Australia, Canada, and Japan;
- Injecting and non-injecting drug users;
- Men who have sex with men (both adolescents and adults);
- People with clotting-factor disorders;
- Persons who work with hepatitis A virus in experimental lab settings (not routine medical labs);
- Food handlers, when health authorities or private employers determine vaccination to be cost effective;
- Persons with chronic liver disease, including persons with hepatitis B and C; and
- Anyone wishing to obtain immunity to hepatitis A.

CDC has specifically focused on addressing hepatitis A and B, along with multiple STDs (including

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HIV/AIDS) among MSM. In March 2004, the directors of four CDC divisions issued a "Dear Colleague" letter outlining the critical need for comprehensive and integrated HIV/STD/viral hepatitis services for MSM. Noting the high rates of HIV and other STDs among MSM, including young MSM and most specifically, young Black MSM, the directors state, "The continued high rates of multiple STDs among MSM underscore the importance and need for the delivery of comprehensive STD prevention services in both public and private sectors. In addition, despite recommendations to vaccinate MSM to prevent hepatitis A and hepatitis B infections, vaccination coverage in this population is low." However, studies have suggested that the majority of MSM would accept hepatitis A vaccination if recommended by their providers. Providers in primary-care and specialty medical settings in which MSM and other at risk populations receive care should offer hepatitis A vaccine to patients at risk.

For more information, contact Valerie Curry or Kevin O'Connor in the Division of Viral Hepatitis (DVH) at CDC, or visit the DVH webpage on MSM.

SAMHSA Hepatitis Vaccination Pilot Project Launched

Article courtesy of SAMHSA News, March/April 2006, Volume 14, Number 2, the newsletter of the Substance Abuse and Mental Health Services Administration.

A new one-year pilot project from the Substance Abuse and Mental Health Service Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT) will provide free vaccine against hepatitis A and hepatitis B. Programs that will distribute the vaccine include the SAMHSA Minority AIDS Initiative Targeted Capacity Expansion grantees, Opioid Treatment Programs regulated by SAMHSA, and treatment sites using the medication buprenorphine for opioid addiction.

The CSAT pilot project is part of an infection prevention measure to reduce the risk of hepatitis A or B in persons who are eligible for services. Those individuals are either infected with HIV (human immunodeficiency virus) or hepatitis C virus (HCV), or they are at high risk for contracting these infections as a consequence of injection drug use or other substance use. Vaccination against hepatitis A and B virus infections can supplement care and improve treatment strategies to prevent progression of liver disease.

Vaccine distribution began in January and will be completed by September 2006. "The vaccine demand has been higher than initial estimates among programs quick to respond to the invitation letter," said Kenneth Hoffman, M.D., M.P.H., Project Officer for the program. "All available vaccine was committed by the end of January."

About 30 sites have agreed to participate in the project. To participate, programs must demonstrate that they have an established immunization program as part of their core treatment or outreach approach. The project will assess the likelihood of reaching individuals at risk for vaccine-preventable infectious hepatitis in methadone and buprenorphine treatment facilities and nontraditional substance abuse prevention and treatment facilities.

Vaccination against hepatitis A and B virus infections can improve treatment strategies to prevent progression of liver disease. HCV, which spreads through contact with an infected person's blood, and HIV are frequent co-occurring infectious diseases in drug users, especially injection drug users. And co-occurring infections complicate the medical management of substance abuse treatment.

Who Is Receiving the Vaccine?

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For persons age 18 and older, CDC recommends immunization for both hepatitis A and B for all susceptible persons who are at risk for either exposure to both viruses, or at risk for serious complications from infection with these viruses. These individuals include residents of drug and alcohol treatment centers and patients with chronic liver disease.

The SAMHSA pilot project purchased Twinrix®, the only combination vaccine for both hepatitis A and hepatitis B. Use of the combined vaccine simplifies the dose schedule by using one vaccine and decreases the number of shots needed for full protection from five shots to three. Even one shot of the combination vaccine can provide significant protection against infection, with up to 50 percent of those vaccinated being protected against hepatitis B for a short time. Additional doses increase the percentage protected up to 75 percent with a second dose, and 90-95 percent with a third dose, and the length of protection is extended to many years. Protection against hepatitis A is even higher with a single dose, and 100 percent after all three doses. Side effects are minimal, the most common being transient fatigue, headache, nausea, or aching following immunization.

SAMHSA, in collaboration with the CDC, has educational materials available to all substance abuse treatment programs and to patients beyond the pilot period, whether or not the site is participating in the demonstration project.

Because the vaccine is given in three separate injections, the program will collect data on whether patients complete the entire vaccination process. An evaluation team will provide data that reflect the demographics and risk factors of people receiving the immunization and the number of immunizations received by those individuals.

The importance of preventing, identifying, and treating hepatitis as part of comprehensive services in an opioid treatment program is covered in detail in a SAMHSA monograph on hepatitis, which will be available soon.

For more information, contact Dr. Kenneth Hoffman in the CSAT Division of Pharmacologic Therapies (240) 276-2701 or visit the SAMHSA website.

Assessing Integration of Viral Hepatitis Services in HIV Prevention Programs from January 1—June 30, 2005: Are Health Departments Integrating Services?
by Kamesha Ellis, MPH, Public Health Prevention Services Fellow, Centers for Disease Control and Prevention

An 11-item assessment was developed in collaboration with CDC's Division of Viral Hepatitis (DVH), Division of HIV/AIDS Prevention (DHAP), and Division of STD Prevention (DSTDP) to assess the level of hepatitis integration services in HIV prevention cooperative agreements to state and local health departments (through Program Announcement 04012). The assessment tool contained four key areas: screening/testing, education, immunization, and referral. In addition to these key areas, CDC assessed populations targeted by city/state health departments and identified the Diffusion of Effective Behavior Intervention (DEBI) models incorporated into their comprehensive HIV prevention plans. The assessment tool was completed based on extracted information from 57 of 59 city/state health department 2005 HIV interim progress reports. Once the assessment tool was developed and data extracted, CDC looked at whether states were integrating hepatitis services and if there was collaboration between HIV prevention programs and immunization, hepatitis, STD, and criminal justice programs.

Eighty-six percent (49/57) of the city/state HIV programs were conducting at least one integration activity. Activities included: hepatitis screening/testing, vaccination, referral, and education. Based on data extracted from the HIV prevention program progress reports, 46 percent offered hepatitis C screenings. Twenty-one percent of city/state HIV programs provided referrals to hepatitis clients. Fifty percent of city/state health departments provided hepatitis A

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and B vaccinations. HIV programs that collaborate with hepatitis programs were more likely to provide hepatitis education and services.

HIV prevention programs are to be commended for improving and expanding prevention services for their clients through integration of viral hepatitis prevention messages and services. Yet much remains to be done. Specific areas include program evaluation, collaboration, comprehensive HIV, STD, and viral hepatitis prevention messages and services, and more comprehensive grantee guidance. HIV programs need to know the number of clients receiving hepatitis C testing, the number of hepatitis A and B vaccinations performed, and number of referrals given for hepatitis services. Prevention programs should design their evaluation activities to assess potential improvements in at risk HIV screening as a result of the incentive offered by more comprehensive services.

Findings showed that all of the city/state HIV prevention programs collaborated with at least one other program within the various health departments. Collaboration is an essential first step to integration and comprehensive service delivery. Finally, it would be beneficial for the different divisions within the CDC to collaborate to develop tools to identify gaps, spotlight effective synergies, strategies, and interventions, and promote overall integration of comprehensive HIV/ STD/hepatitis services at the state and local level.

CDC and Congress: Working Together to Increase Awareness about Hepatitis B and Its Impact on Asian American and Pacific Islanders

Representative Mike Honda, 15th District of California (D), and the chair of the Asian Pacific-American Caucus, is a champion of nationwide hepatitis prevention initiatives. In 2005, Rep. Honda and Rep. Charlie Dent, 15th District of Pennsylvania (R), introduced the first ever hepatitis B virus bill (H.R. 4550), entitled "The National Hepatitis B Act." This bill would amend the Public Health Service Act to direct the Secretary of Health and Human Services to establish, promote, and support a comprehensive prevention, education, research, and medical management program that will contribute to a marked reduction in liver cirrhosis and a reduction in the cases of, and improved survival of, liver cancer caused by chronic hepatitis B virus (HBV) infection.

"The Division appreciates Rep. Honda's concern for persons at risk for hepatitis B and his efforts to prevent new infections and protect the health of those already infected with HBV," says John W. Ward, Director of CDC's Division of Viral Hepatitis.

HBV infection and related deaths are a major cause of illness and deaths among Asian and Pacific Islanders (APIs). HBV is among the top ten leading causes of infectious disease deaths worldwide. An estimated 1.25 million Americans have chronic HBV infection; many of these persons are Asian American. In 2002, the hepatitis B-related death rate among Asian Americans was six times higher than the rate among whites.

With bi-partisan support, Congress designated May 14-20, 2006 as the first National Hepatitis B Awareness Week. In addition to National Hepatitis Awareness Month, May is also National Asian American and Pacific Islander Heritage Month. In honor of these observances, Rep. Honda will visit CDC to participate in a program recognizing API health and heritage. The tentative topic of his talk is "Addressing Health Disparities in Asian and Pacific Islander Americans: Viral Hepatitis, Diabetes, and Cancer."

For more information, visit the DVH website.

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Partner Profile: The Hepatitis B Foundation
by Molli Conti, Vice President for Community Outreach

The Hepatitis B Foundation is a national nonprofit organization founded in 1991 dedicated to finding a cure and improving the quality of life for those affected by hepatitis B worldwide. Its commitment includes funding focused research, promoting disease awareness, supporting immunization and treatment initiatives, and serving as the primary source of information for patients and their families, the medical and scientific community, and the general public. There are 400 million reasons why its mission remains so urgent – a cure must still be found for the 400 million people who suffer from chronic hepatitis B worldwide.

Research and Education Rooted in Human Compassion

Over the past years, the HBF has developed a comprehensive research, education and patient advocacy program to achieve its mission of helping those affected by hepatitis B. HBF provides information and support to individuals and families through its dedicated website that includes language chapters of translated information, e-mail and telephone help-lines, free newsletters and educational literature, a national directory of liver specialists, and the first and only national patient conference for those affected.

HBF funds a research institute, the *Institute for Hepatitis and Virus Research*, and support scientists working on hepatitis B through fellowships and internships and through support for conference presentations, such as the Princeton Workshop focused on innovative hepatitis B therapeutic strategies.

Partnerships for National Advocacy

As the only organization solely dedicated to those affected by hepatitis B, HBF is often invited to provide testimony to key legislators and has successfully advocated for funds to support hepatitis B prevention, education and research programs. For example, work done by the HBF through its collaboration with Bristol-Myers Squibb on the *AIM for the B Campaign*, helped prompt a bi-partisan congressional resolution naming May as National Hepatitis B Awareness Month. In addition, the HBF moderated the first *Congressional Briefing on Hepatitis B*, sponsored by U.S. Senator Rick Santorum (R-PA), in July 2005.

Hope for a Cure

As researchers have begun to focus on how the hepatitis B virus works, more promising drugs are becoming available. There are now five FDA-approved drugs, and many other medicines in the research pipeline. HBF scientists are contributing to the progress of hepatitis B research through an aggressive drug discovery program (see “Drug Watch” or subscribe to the free B Informed newsletter on the HBF website).

Although the initial hope was that there would be a magic bullet to cure hepatitis B, none of the individual drugs to date offer a complete cure. Experts agree the most effective therapy will probably include a combination of several drugs. The best way to halt the hepatitis B virus may be to employ two strategies – one aimed to attack viral replication, the other targeted to strengthen the immune system.

The two-pronged approach, however, raises a slew of questions such as what will be the most effective combination, should the drugs be given together or sequentially, and which patients are

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the best candidates for these therapies? Despite the many unanswered questions, it is encouraging to remember that the strides made in the 15 years represent a huge step forward toward turning the tide against hepatitis B. There is certainly good reason to hope that a cure is on the near horizon.

Future Directions

Key issues the HBF has identified as areas of great need include primary liver cancer, of which 80 percent of cases worldwide are caused by chronic hepatitis B, and improving hepatitis B surveillance methods.

Liver cancer is the only cancer that is rapidly increasing in the U.S., according to the National Cancer Institute, and is the eighth most common cause of cancer deaths in this country. Researchers attribute this increase to the large number of Americans chronically infected with hepatitis B, and to a lesser extent hepatitis C, both of which increase the risk of progressing to fatal liver cancer.

The stunning rise in liver cancer indicates there are a much greater number of people chronically infected with hepatitis B in the U.S. Over the past decade, there has been an enormous wave of new immigrants from countries where hepatitis B is highly prevalent. This raises the question as to whether there is an invisible community of perhaps more than a million more individuals with chronic hepatitis B who have not been counted in surveillance studies. Hence, the 1.25 million Americans affected with chronic hepatitis B, a figure based on data from 20 years ago, may seriously under-represent the true number of chronic infections. The implications are profound since health care policy and budgets are influenced by these statistics.

With the rise in liver cancer and the real possibility that there may be a million more people living with chronic hepatitis B in the U.S. who have not been counted, making certain that hepatitis B is not forgotten has never been more important.

For more information, visit the HBF website or call (215) 489-4900.

Northeast Hepatitis C Coordinators' Alliance
*by Colleen Flanigan, New York State Department of Hea*lth

The Hepatitis C Coordinators located in the northeast region of the U.S. have joined together to form an alliance to facilitate a collaborative approach to hepatitis C prevention. The Northeast Hepatitis C Coordinators' Alliance (NHCCA), is made up of ten coordinators located at the state and city levels: Andrea Lombard (CT), Dan Church (MA), Mary Kate Appicelli (ME), Thandi Tshabangu-Soko (NH), Sandra Van Sant (NJ), Eric Rude (NYC), Colleen Flanigan (NYS), Owen Simwale (PA), Tamara Brickman (Philadelphia), and Lorraine Moynihan (RI). Given the limited resources for hepatitis C prevention, the group was formed to help maximize existing resources and elevate the significance of its efforts through a unified approach.

NHCCA's goals are to provide more in-depth and quality communication between states that is often not possible through national conference calls or conferences; learn practical strategies for program implementation (e.g., best practices, model programs); and enhance public health skills tailored to all its hepatitis C activities (e.g. advocacy, community organization, and other relevant trainings).

NHCCA is planning its first meeting August 8-9 in New York City (sponsored by New York's Fund

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for Public Health). Each coordinator will have equal opportunity to provide input into the agenda. The objectives of this meeting are to:

1. Select and prioritize future activities of NHCCA;
2. Identify services and/or programs available in the region that will assist in the overall improvement of hepatitis C programs;
3. Describe strategies to improve advocacy;
4. Identify best practice methods for providing education to targeted groups; and
5. List strategies for overcoming funding and other programmatic barriers.

The American Liver Foundation will host a gathering in the evening, which will give coordinators an opportunity to meet with community advocacy groups such as the Harm Reduction Coalition, Treatment Advocacy Group, National AIDS Treatment Advocacy Program, and the Hepatitis C Association.

In addition to the August meeting, NHCCA members have conferred via conference call to collaborate on activities to promote National Viral Hepatitis Awareness Month throughout the northeast. While most states' awareness month efforts focus on viral hepatitis, NHCCA's focuses primarily on hepatitis C, including the development of a poster to raise awareness for hepatitis C. The poster highlights the risk factors for hepatitis C and encourages individuals to get tested. Eight states/cities will offer free hepatitis C testing during May, and the poster will be used to promote the free testing. The poster also includes a logo depicting the alliance between each northeast state and city. NHCCA will also develop a press release that will be shared among each state and city.

For more information, contact Colleen Flanigan, Hepatitis C Coordinator, New York State Department of Health (518) 486-2938.

Capacity Building Calendar

Information on CDC-sponsored Capacity Building Assistance trainings for May-July is now available.

Meeting and Planning Calendar

May 2-6, 2006
"Embracing Our Traditions, Values and Teaching: Native People of North America HIV/AIDS Conference," Anchorage, AK. Presented by Inter-Tribal Council of Michigan, Inc. Currently accepting abstracts on Research, Mental Health, Prevention, Special Populations and Stigma, Spiritual Issues and Leadership, and Treatment, Care and Support. For more information, visit the conference website.

May 8–11, 2006
National STD Prevention Conference, Jacksonville, FL. "Beyond The Hidden Epidemic: Evolution or Revolution?" For more information, visit the conference website.

May 19, 2006
National Asian and Pacific Islander HIV/AIDS Awareness Day. For more information, visit the event website.

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May 19 -20, 2006
ABA HIV/AIDS Law & Practice Conference, in Portland, Oregon. For more information, visit the conference website.

May 25-28, 2006
"HIV/AIDS 2006: The Social Work Response." Eighteenth Annual National Conference on Social Work and HIV/AIDS, Miami, FL. Sponsored by the Boston College Graduate School of Social Work. For more information, contact Vincent Lynch (617) 552-4038.

June 4-7, 2006
HIV Prevention Leadership Summit (HPLS), Dallas, TX. For more information, visit the conference website.

June 7-10, 2006
"Building the Movement." National Mental Health Association's Annual Meeting, Washington, D.C. For more information, visit the conference website.

June 22-25, 2006
A National Symposium: Global Health Care Justice, Hiram, OH. For more information, visit the symposium website.

June 27, 2006
National HIV Testing Day. Sponsored by the National Association of People With AIDS. For more information, visit the event website.

August 13-18, 2006
XVI International AIDS Conference, Toronto, Canada. Abstract submissions due February 22, 2006. For more information, visit the conference website.

August 28-31, 2006
The Ryan White CARE Act Grantee Conference and the 9th Annual Clinical Conference Update, Washington, DC. Workshop and poster presentations will be grouped under six tracks: 1) access to care; 2) quality; 3) program development; 4) coordination and linkages; 5) administration (fiscal and program management); and 6) data evaluation and outcomes. For more information visit the conference website.

September 12-14, 2006
CDC's 2006 National Health Promotion Conference: Innovations in Health Promotion: New Avenues for Collaboration, Atlanta, GA. For more information, visit the conference website.

September 24-26, 2006
United States Conference on AIDS (USCA), Hollywood, FL. For more information, visit the conference website.

October 15, 2006
National Latino HIV/AIDS Awareness Day. For more information, visit the event website.

November 4-8, 2006
"Public Health and Human Rights," American Public Health Association's 134th Annual Meeting,

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Boston, MA. For more information, visit the conference website.

November 9 – 12, 2006
Sixth National Harm Reduction Conference, Oakland, CA. For more information, visit the conference website.

December 1, 2006
World AIDS Day. For more information, visit the event website.

April 5-7, 2007
"HIV/STD Prevention in Rural Communities: Sharing Successful Strategies V," the Rural Center for AIDS/STD Prevention national conference, Indiana University, Bloomington, IN. A call for papers will be issued in fall 2006. For more information, visit the conference website.

If you have an idea or program relative to any of these topics that you would like to include in the *Bulletin*, please contact Nyedra Booker (202/434-8090). The NASTAD *HIV Prevention Bulletin* is written and edited by NASTAD staff and participants of community planning and prevention efforts around the country.

NASTAD's production of the *Bulletin* is made possible through funding provided by CDC's Division of HIV/AIDS Prevention (DHAP) in the National Center for HIV, STD, and TB Prevention.

LET US KNOW WHAT YOU THINK! NASTAD welcomes feedback to issues presented in our newsletter. To submit commentary, please e-mail us at NASTAD@NASTAD.org.

Visit our Webpage! Electronic versions of the *Bulletin* are posted along with other information on both NASTAD's prevention and care projects.

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